December 9, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0350-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in anesthesiology. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 36 year-old female who sustained a work related injury to her back on ___ when she attempted to stop a falling cart with an ice chest on it. The patient sustained a Lumbar Sprain/Strain. X-Ray on 4/17/02 showed lumbar lordosis. An MRI showed annular disc bulge at L5-S1. The patient also had EMG testing. Treatment has included chiropractic manipulations and pain medications.

Requested Services

Lumbar Facet and SI Joint Injections.

Decision

The Carrier's denial of authorization and coverage for the requested services is overturned.

Rationale/Basis for Decision

___ physician reviewer noted that a review of the medical records provided indicated the patient sustained a work related injury to her back on ___. ___ physician reviewer also noted that this injury causes axial pain radiating down both legs, and that the pain in the back is worse than the pain in the legs, worsening when she stands and hyper-extends. ___ physician reviewer further noted that the patient experiences numbness and weakness that radiates down both legs, more to the left than right, after standing for any significant period of time. ___ physician reviewer noted that the documentation provided indicates that conservative treatment modalities have not provided long-term pain relief. ___ physician reviewer indicated that the patient was evaluated by a pain management specialist who concluded that the she had a lumbo-sacral strain and

would benefit from lumbar facet block with sacroiliac injections, followed by rehabilitation with emphasis upon extension exercises and strengthening of the lumbar spinal stabilization muscles. ___ physician reviewer explained that facet joint blocks can also be used as an additional therapy for suspected facet joint syndrome in patients when symptoms fail to respond to conservative treatment for low back pain. Therefore, ___ physician consultant has concluded that the requested injection therapy is medically indicated for the treatment of this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,